

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

JESSICA RENEE FARREN
34528 Northstar Terrace
Fremont, CA 94555

Registered Nurse License No. 661425

Respondent

Case No. 2013-355

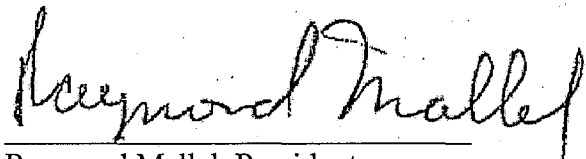
OAH No. 2012120359

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on **May 10, 2013.**

IT IS SO ORDERED **April 10, 2013.**



Raymond Mallel, President
Board of Registered Nursing
Department of Consumer Affairs
State of California

1 KAMALA D. HARRIS
Attorney General of California
2 FRANK H. PACOE
Supervising Deputy Attorney General
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Attorneys for Complainant

7
8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **JESSICA RENEE FARREN**
14 **34528 Northstar Terrace**
15 **Fremont, CA 94555**

16 **Registered Nursing License No. 661425**

17 Respondent.

Case No. 2013-355

OAH No. 2012120359

18 **STIPULATED SETTLEMENT AND**
19 **DISCIPLINARY ORDER**

20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 PARTIES

23 1. Louise R. Bailey, M.Ed., RN (Complainant) is the Executive Officer of the Board of
24 Registered Nursing. She brought this action solely in her official capacity and is represented in
25 this matter by Kamala D. Harris, Attorney General of the State of California, by Char Sachson,
26 Deputy Attorney General.

27 2. Respondent Jessica Renee Farren (Respondent) is represented in this proceeding by
28 attorney Samuel Spital, whose address is: 8880 Rio San Diego Drive, Ste. 800, San Diego, CA
92108-1642.

3. On or about July 22, 2005, the Board of Registered Nursing issued Registered
Nursing License No. 661425 to Respondent. The Registered Nursing License was in full force

1 and effect at all times relevant to the charges brought in Accusation No. 2013-355 and will expire
2 on April 30, 2013, unless renewed.

3 JURISDICTION

4 4. Accusation No. 2013-355 was filed before the Board of Registered Nursing (Board),
5 Department of Consumer Affairs, and is currently pending against Respondent. The Accusation
6 and all other statutorily required documents were properly served on Respondent on November 1,
7 2012. Respondent timely filed her Notice of Defense contesting the Accusation.

8 5. A copy of Accusation No. 2013-355 is attached as exhibit A and incorporated herein
9 by reference.

10 ADVISEMENT AND WAIVERS

11 6. Respondent has carefully read, fully discussed with counsel, and understands the
12 charges and allegations in Accusation No. 2013-355. Respondent has also carefully read, fully
13 discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary
14 Order.

15 7. Respondent is fully aware of her legal rights in this matter, including the right to a
16 hearing on the charges and allegations in the Accusation; the right to be represented by counsel at
17 her own expense; the right to confront and cross-examine the witnesses against her; the right to
18 present evidence and to testify on her own behalf; the right to the issuance of subpoenas to
19 compel the attendance of witnesses and the production of documents; the right to reconsideration
20 and court review of an adverse decision; and all other rights accorded by the California
21 Administrative Procedure Act and other applicable laws.

22 8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and
23 every right set forth above.

24 CULPABILITY

25 9. Respondent admits the truth of each and every charge and allegation in Accusation
26 No. 2013-355.

27 10. Respondent agrees that her Registered Nursing License is subject to discipline and
28 she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order

below.

CIRCUMSTANCES IN MITIGATION

11. Respondent Jessica Renee Farren has never been the subject of any disciplinary action. She is admitting responsibility at an early stage in the proceedings.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Board of Registered Nursing or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

15. This Stipulated Settlement and Disciplinary Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Settlement and Disciplinary

Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Registered Nursing License No. 661425 issued to Respondent Jessica Renee Farren (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

Severability Clause. Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

1. **Obey All Laws.** Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by Respondent to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, Respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

Criminal Court Orders: If Respondent is under criminal court orders, including probation or parole, and the order is violated, this shall be deemed a violation of these probation conditions, and may result in the filing of an accusation and/or petition to revoke probation.

2. **Comply with the Board's Probation Program.** Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of the Respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license

1 status with the Board, including during any period of suspension.

2 Upon successful completion of probation, Respondent's license shall be fully restored.

3 **3. Report in Person.** Respondent, during the period of probation, shall appear in
4 person at interviews/meetings as directed by the Board or its designated representatives.

5 **4. Residency, Practice, or Licensure Outside of State.** Periods of residency or
6 practice as a registered nurse outside of California shall not apply toward a reduction of this
7 probation time period. Respondent's probation is tolled, if and when she resides outside of
8 California. Respondent must provide written notice to the Board within 15 days of any change of
9 residency or practice outside the state, and within 30 days prior to re-establishing residency or
10 returning to practice in this state.

11 Respondent shall provide a list of all states and territories where she has ever been licensed
12 as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide
13 information regarding the status of each license and any changes in such license status during the
14 term of probation. Respondent shall inform the Board if she applies for or obtains a new nursing
15 license during the term of probation.

16 **5. Submit Written Reports.** Respondent, during the period of probation, shall submit
17 or cause to be submitted such written reports/declarations and verification of actions under
18 penalty of perjury, as required by the Board. These reports/declarations shall contain statements
19 relative to Respondent's compliance with all the conditions of the Board's Probation Program.
20 Respondent shall immediately execute all release of information forms as may be required by the
21 Board or its representatives.

22 Respondent shall provide a copy of this Decision to the nursing regulatory agency in every
23 state and territory in which she has a registered nurse license.

24 **6. Function as a Registered Nurse.** Respondent, during the period of probation, shall
25 engage in the practice of registered nursing in California for a minimum of 24 hours per week for
26 6 consecutive months or as determined by the Board.

27 For purposes of compliance with the section, "engage in the practice of registered nursing"
28 may include, when approved by the Board, volunteer work as a registered nurse, or work in any

1 non-direct patient care position that requires licensure as a registered nurse.

2 The Board may require that advanced practice nurses engage in advanced practice nursing
3 for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

4 If Respondent has not complied with this condition during the probationary term, and
5 Respondent has presented sufficient documentation of her good faith efforts to comply with this
6 condition, and if no other conditions have been violated, the Board, in its discretion, may grant an
7 extension of Respondent's probation period up to one year without further hearing in order to
8 comply with this condition. During the one year extension, all original conditions of probation
9 shall apply.

10 **7. Employment Approval and Reporting Requirements.** Respondent shall obtain
11 prior approval from the Board before commencing or continuing any employment, paid or
12 voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all
13 performance evaluations and other employment related reports as a registered nurse upon request
14 of the Board.

15 Respondent shall provide a copy of this Decision to her employer and immediate
16 supervisors prior to commencement of any nursing or other health care related employment.

17 In addition to the above, Respondent shall notify the Board in writing within seventy-two
18 (72) hours after she obtains any nursing or other health care related employment. Respondent
19 shall notify the Board in writing within seventy-two (72) hours after she is terminated or
20 separated, regardless of cause, from any nursing, or other health care related employment with a
21 full explanation of the circumstances surrounding the termination or separation.

22 **8. Supervision.** Respondent shall obtain prior approval from the Board regarding
23 Respondent's level of supervision and/or collaboration before commencing or continuing any
24 employment as a registered nurse, or education and training that includes patient care.

25 Respondent shall practice only under the direct supervision of a registered nurse in good
26 standing (no current discipline) with the Board of Registered Nursing, unless alternative methods
27 of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are
28 approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours Respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with Respondent at least twice during each shift worked.

(d) Home Health Care - If Respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with Respondent as required by the Board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by Respondent with or without Respondent present.

9. Employment Limitations. Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict Respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

Respondent shall work only on a regularly assigned, identified and predetermined

1 worksite(s) and shall not work in a float capacity.

2 If Respondent is working or intends to work in excess of 40 hours per week, the Board may
3 request documentation to determine whether there should be restrictions on the hours of work.

4 **10. Complete a Nursing Course(s).** Respondent, at her own expense, shall enroll and
5 successfully complete a course(s) relevant to the practice of registered nursing no later than six
6 months prior to the end of her probationary term.

7 Respondent shall obtain prior approval from the Board before enrolling in the course(s).
8 Respondent shall submit to the Board the original transcripts or certificates of completion for the
9 above required course(s). The Board shall return the original documents to Respondent after
10 photocopying them for its records.

11 **11. Cost Recovery.** Respondent shall pay to the Board costs associated with its
12 investigation and enforcement pursuant to Business and Professions Code section 125.3 in the
13 amount of \$6,615.03 Respondent shall be permitted to pay these costs in a payment plan
14 approved by the Board, with payments to be completed no later than three months prior to the end
15 of the probation term.

16 If Respondent has not complied with this condition during the probationary term, and
17 Respondent has presented sufficient documentation of her good faith efforts to comply with this
18 condition, and if no other conditions have been violated, the Board, in its discretion, may grant an
19 extension of Respondent's probation period up to one year without further hearing in order to
20 comply with this condition. During the one year extension, all original conditions of probation
21 will apply.

22 **12. Violation of Probation.** If Respondent violates the conditions of her probation, the
23 Board after giving Respondent notice and an opportunity to be heard, may set aside the stay order
24 and impose the stayed discipline (revocation/suspension) of Respondent's license.

25 If during the period of probation, an accusation or petition to revoke probation has been
26 filed against Respondent's license or the Attorney General's Office has been requested to prepare
27 an accusation or petition to revoke probation against Respondent's license, the probationary
28 period shall automatically be extended and shall not expire until the accusation or petition has

1 been acted upon by the Board.

2 13. **License Surrender.** During Respondent's term of probation, if she ceases practicing
3 due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation,
4 Respondent may surrender her license to the Board. The Board reserves the right to evaluate
5 Respondent's request and to exercise its discretion whether to grant the request, or to take any
6 other action deemed appropriate and reasonable under the circumstances, without further hearing.
7 Upon formal acceptance of the tendered license and wall certificate, Respondent will no longer be
8 subject to the conditions of probation.

9 Surrender of Respondent's license shall be considered a disciplinary action and shall
10 become a part of Respondent's license history with the Board. A registered nurse whose license
11 has been surrendered may petition the Board for reinstatement no sooner than the following
12 minimum periods from the effective date of the disciplinary decision:

- 13 (1) Two years for reinstatement of a license that was surrendered for any reason other
14 than a mental or physical illness; or
15 (2) One year for a license surrendered for a mental or physical illness.

16 14. **Physical Examination.** Within 45 days of the effective date of this Decision,
17 Respondent, at her expense, shall have a licensed physician, nurse practitioner, or physician
18 assistant, who is approved by the Board before the assessment is performed, submit an
19 assessment of the Respondent's physical condition and capability to perform the duties of a
20 registered nurse. Such an assessment shall be submitted in a format acceptable to the Board. If
21 medically determined, a recommended treatment program will be instituted and followed by the
22 Respondent with the physician, nurse practitioner, or physician assistant providing written reports
23 to the Board on forms provided by the Board.

24 If Respondent is determined to be unable to practice safely as a registered nurse, the
25 licensed physician, nurse practitioner, or physician assistant making this determination shall
26 immediately notify the Board and Respondent by telephone, and the Board shall request that the
27 Attorney General's office prepare an accusation or petition to revoke probation. Respondent shall
28 immediately cease practice and shall not resume practice until notified by the Board. During this

1 period of suspension, Respondent shall not engage in any practice for which a license issued by
2 the Board is required until the Board has notified Respondent that a medical determination
3 permits Respondent to resume practice. This period of suspension will not apply to the reduction
4 of this probationary time period.

5 If Respondent fails to have the above assessment submitted to the Board within the 45-day
6 requirement, Respondent shall immediately cease practice and shall not resume practice until
7 notified by the Board. This period of suspension will not apply to the reduction of this
8 probationary time period. The Board may waive or postpone this suspension only if significant,
9 documented evidence of mitigation is provided. Such evidence must establish good faith efforts
10 by Respondent to obtain the assessment, and a specific date for compliance must be provided.
11 Only one such waiver or extension may be permitted.

12 **15. Participate in Treatment/Rehabilitation Program for Chemical Dependence.**

13 Respondent, at her expense, shall successfully complete during the probationary period or shall
14 have successfully completed prior to commencement of probation a Board-approved
15 treatment/rehabilitation program of at least six months duration. As required, reports shall be
16 submitted by the program on forms provided by the Board. If Respondent has not completed a
17 Board-approved treatment/rehabilitation program prior to commencement of probation,
18 Respondent, within 45 days from the effective date of the decision, shall be enrolled in a program.
19 If a program is not successfully completed within the first nine months of probation, the Board
20 shall consider Respondent in violation of probation.

21 Based on Board recommendation, each week Respondent shall be required to attend at least
22 one, but no more than five 12-step recovery meetings or equivalent (e.g., Narcotics Anonymous,
23 Alcoholics Anonymous, etc.) and a nurse support group as approved and directed by the Board.
24 If a nurse support group is not available, an additional 12-step meeting or equivalent shall be
25 added. Respondent shall submit dated and signed documentation confirming such attendance to
26 the Board during the entire period of probation. Respondent shall continue with the recovery plan
27 recommended by the treatment/rehabilitation program or a licensed mental health examiner
28 and/or other ongoing recovery groups.

1 **16. Abstain from Use of Psychotropic (Mood-Altering) Drugs.** Respondent shall
2 completely abstain from the possession, injection or consumption by any route of all controlled
3 substances and all psychotropic (mood altering) drugs, including alcohol, except when the same
4 are ordered by a health care professional legally authorized to do so as part of documented
5 medical treatment. Respondent shall have sent to the Board, in writing and within fourteen (14)
6 days, by the prescribing health professional, a report identifying the medication, dosage, the date
7 the medication was prescribed, the Respondent's prognosis, the date the medication will no
8 longer be required, and the effect on the recovery plan, if appropriate.

9 Respondent shall identify for the Board a single physician, nurse practitioner or physician
10 assistant who shall be aware of Respondent's history of substance abuse and will coordinate and
11 monitor any prescriptions for Respondent for dangerous drugs, controlled substances or mood-
12 altering drugs. The coordinating physician, nurse practitioner, or physician assistant shall report
13 to the Board on a quarterly basis Respondent's compliance with this condition. If any substances
14 considered addictive have been prescribed, the report shall identify a program for the time limited
15 use of any such substances.

16 The Board may require the single coordinating physician, nurse practitioner, or physician
17 assistant to be a specialist in addictive medicine, or to consult with a specialist in addictive
18 medicine.

19 **17. Submit to Tests and Samples.** Respondent, at her expense, shall participate in a
20 random, biological fluid testing or a drug screening program which the Board approves. The
21 length of time and frequency will be subject to approval by the Board. Respondent is responsible
22 for keeping the Board informed of Respondent's current telephone number at all times.
23 Respondent shall also ensure that messages may be left at the telephone number when she is not
24 available and ensure that reports are submitted directly by the testing agency to the Board, as
25 directed. Any confirmed positive finding shall be reported immediately to the Board by the
26 program and Respondent shall be considered in violation of probation.

27 In addition, Respondent, at any time during the period of probation, shall fully cooperate
28 with the Board or any of its representatives, and shall, when requested, submit to such tests and

1 samples as the Board or its representatives may require for the detection of alcohol, narcotics,
2 hypnotics, dangerous drugs, or other controlled substances.

3 If Respondent has a positive drug screen for any substance not legally authorized and not
4 reported to the coordinating physician, nurse practitioner, or physician assistant, and the Board
5 files a petition to revoke probation or an accusation, the Board may suspend Respondent from
6 practice pending the final decision on the petition to revoke probation or the accusation. This
7 period of suspension will not apply to the reduction of this probationary time period.

8 If Respondent fails to participate in a random, biological fluid testing or drug screening
9 program within the specified time frame, Respondent shall immediately cease practice and shall
10 not resume practice until notified by the Board. After taking into account documented evidence
11 of mitigation, if the Board files a petition to revoke probation or an accusation, the Board may
12 suspend Respondent from practice pending the final decision on the petition to revoke probation
13 or the accusation. This period of suspension will not apply to the reduction of this probationary
14 time period.

15 **18. Mental Health Examination.** Respondent shall, within 45 days of the effective date
16 of this Decision, have a mental health examination including psychological testing as appropriate
17 to determine her capability to perform the duties of a registered nurse. The examination will be
18 performed by a psychiatrist, psychologist or other licensed mental health practitioner approved by
19 the Board. The examining mental health practitioner will submit a written report of that
20 assessment and recommendations to the Board. All costs are the responsibility of Respondent.
21 Recommendations for treatment, therapy or counseling made as a result of the mental health
22 examination will be instituted and followed by Respondent.

23 If Respondent is determined to be unable to practice safely as a registered nurse, the
24 licensed mental health care practitioner making this determination shall immediately notify the
25 Board and Respondent by telephone, and the Board shall request that the Attorney General's
26 office prepare an accusation or petition to revoke probation. Respondent shall immediately cease
27 practice and may not resume practice until notified by the Board. During this period of
28 suspension, Respondent shall not engage in any practice for which a license issued by the Board

Respondent to resume practice. This period of suspension will not apply to the reduction of this probationary time period.

If Respondent fails to have the above assessment submitted to the Board within the 45-day requirement, Respondent shall immediately cease practice and shall not resume practice until notified by the Board. This period of suspension will not apply to the reduction of this probationary time period. The Board may waive or postpone this suspension only if significant, documented evidence of mitigation is provided. Such evidence must establish good faith efforts by Respondent to obtain the assessment, and a specific date for compliance must be provided. Only one such waiver or extension may be permitted.

19. **Therapy or Counseling Program.** Respondent, at her expense, shall participate in an on-going counseling program until such time as the Board releases her from this requirement and only upon the recommendation of the counselor. Written progress reports from the counselor will be required at various intervals.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Samuel Spital. I understand the stipulation and the effect it will have on my Registered Nursing License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: Jan. 9, 2013

Jessica Renee Farren
JESSICA RENEE FARREN
Respondent

I have read and fully discussed with Respondent Jessica Renee Farren the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 1/10/2013

Samuel Spital
Attorney for Respondent

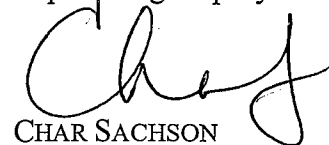
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

Dated: 1/13/13

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
FRANK H. PACOE
Supervising Deputy Attorney General



CHAR SACHSON
Deputy Attorney General
Attorneys for Complainant

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40626980.doc

Exhibit A

Accusation No. 2013-355

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2 FRANK H. PACOE
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Attorneys for Complainant

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9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2013-355

13 **JESSICA RENEE FARREN**
14 **34528 Northstar Terrace**
15 **Fremont, CA 94555**

ACCUSATION

Registered Nursing License No. 661425

Respondent.

16 Complainant alleges:

17 **PARTIES**

18 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
19 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
20 Consumer Affairs.

21 2. On or about July 22, 2005, the Board of Registered Nursing issued Registered
22 Nursing License Number 661425 to Jessica Renee Farren (Respondent). The Registered Nursing
23 License was in full force and effect at all times relevant to the charges brought herein and will
24 expire on April 30, 2013, unless renewed.

25 **JURISDICTION**

26 3. This Accusation is brought before the Board of Registered Nursing (Board),
27 Department of Consumer Affairs, under the authority of the following laws. All section
28 references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

• • • 11

8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to

1 himself or herself, any other person, or the public or to the extent that such use impairs his or her
2 ability to conduct with safety to the public the practice authorized by his or her license.

3 "(c) Be convicted of a criminal offense involving the prescription, consumption, or
4 self-administration of any of the substances described in subdivisions (a) and (b) of this section,
5 or the possession of, or falsification of a record pertaining to, the substances described in
6 subdivision (a) of this section, in which event the record of the conviction is conclusive evidence
7 thereof.

8 "(d) Be committed or confined by a court of competent jurisdiction for intemperate use of
9 or addiction to the use of any of the substances described in subdivisions (a) and (b) of this
10 section, in which event the court order of commitment or confinement is prima facie evidence of
11 such commitment or confinement.

12 "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any
13 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this
14 section."

15 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
16 administrative law judge to direct a licensee found to have committed a violation or violations of
17 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
18 enforcement of the case.

19 10. Health and Safety Code section 11173(a) states, in pertinent part, that no person shall
20 obtain or attempt to obtain controlled substances, or procure or attempt to procure the
21 administration of or prescription for controlled substances by fraud, deceit, misrepresentation or
22 subterfuge.

23 11. Code section 4060 provides, in pertinent part, that no person shall possess any
24 controlled substance, except that furnished upon a valid prescription/drug order.

25 12. Health and Safety Code section 11377, in pertinent part, makes it unlawful to possess
26 any controlled substance in Schedule II, subdivision (d), without a prescription.

27 13. Title 16, California Code of Regulations, section 1443.5 states:
28

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

DRUGS

14. Morphine is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(L), and a dangerous drug as designated by Code section 4022. It is used to treat moderate to severe pain.

15. Hydromorphone hydrochloride, also known as Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b) and a dangerous drug as designated by Business and Professions Code section 4022, used for pain relief.

FIRST CAUSE FOR DISCIPLINE

(FALSIFY, OR MAKE GROSSLY INCORRECT, GROSSLY INCONSISTENT, OR UNINTELLIGIBLE ENTRIES IN ANY PATIENT RECORD)

16. Respondent is subject to disciplinary action under Code section 2762(e), in that while on duty as a registered nurse at Stanford Hospital and Clinics, Stanford, California, Respondent falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records, as follows:

Patient A:

17. On January 24, 2011 at 13:36, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis.¹ Respondent charted wastage of 1 mg of the medication at 13:36 and administration of 1 mg of the medication at 13:41. Respondent failed to document a pain assessment for the patient.

18. On January 24, 2011 at 14:24, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 14:24 and administration of 1 mg of the medication at 14:29. Respondent failed to document the patient's pain assessment, and administered the medication sooner than the physician's order which specified that the patient should be given 1-2 mg of hydromorphone every three hours as needed.

19. On January 24, 2011 at 16:59, Respondent's coworker withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 16:59, and administration of 1 mg of the medication at 17:07. At 16:25, Respondent's coworker had documented that the patient's pain level was "0." At 17:13, Respondent's coworker documented that the patient's pain level was still at "0."

¹ Pyxis is a hospital computerized medication storage system.

1 20. On January 26, 2011 at 07:13, Respondent withdrew 2 mg of hydromorphone from
2 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 07:13 and
3 administration of 1 mg of the medication at 07:23. Respondent failed to document a pain
4 assessment for the patient.

5 21. On January 26, 2011 at 08:24, Respondent withdrew 2 mg of hydromorphone from
6 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 08:24 and
7 administration of 1 mg of the medication at 08:29. Respondent failed to document a pain
8 assessment for the patient, and administered the medication sooner than the physician's order
9 which specified that the patient should be given 1-2 mg of hydromorphone every three hours as
10 needed.

11 22. On January 26, 2011 at 10:32, Respondent withdrew 2 mg of hydromorphone from
12 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 10:32 and
13 administration of 1 mg of the medication at 10:36. Respondent failed to document a pain
14 assessment for the patient, and administered the medication sooner than the physician's order
15 which specified that the patient should be given 1-2 mg of hydromorphone every three hours as
16 needed.

17 23. On January 26, 2011 at 12:32, Respondent withdrew 2 mg of hydromorphone from
18 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 12:32 and
19 administration of 1 mg of the medication at 12:35. Respondent failed to document a pain
20 assessment for the patient, and administered the medication sooner than the physician's order
21 which specified that the patient should be given 1-2 mg of hydromorphone every three hours as
22 needed.

23 24. On January 26, 2011 at 13:45, Respondent withdrew 2 mg of hydromorphone from
24 the hospital Pyxis. Respondent charted wastage of 2 mg of the medication at 14:09 and failed to
25 chart administration of the medication. Respondent held the medication for 24 minutes prior to
26 wasting it and withdrew medication sooner than the physician's order which specified that the
27 patient should be given 1-2 mg of hydromorphone every three hours as needed.
28

1 25. On January 26, 2011 at 15:06, Respondent's coworker withdrew 2 mg of
2 hydromorphone from the hospital Pyxis and wasted 1 mg of the medication at 15:06. Respondent
3 documented administration of 1 mg of the medication at 15:12, but failed to document an
4 assessment of the patient's pain.

5 26. On January 26, 2011 at 16:57, Respondent withdrew 2 mg of hydromorphone from
6 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 16:57 and
7 administration of 1 mg of the medication at 17:03. Respondent failed to document a pain
8 assessment for the patient, and administered the medication sooner than the physician's order
9 which specified that the patient should be given 1-2 mg of hydromorphone every three hours as
10 needed.

11 27. On January 26, 2011 at 18:46, Respondent withdrew 2 mg of hydromorphone from
12 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 18:46 and
13 administration of 1 mg of the medication at 18:49. Respondent failed to document a pain
14 assessment for the patient, and administered the medication sooner than the physician's order
15 which specified that the patient should be given 1-2 mg of hydromorphone every three hours as
16 needed.

17 Patient B:

18 28. On February 12, 2011 at 10:32, Respondent withdrew 2 mg of hydromorphone from
19 the hospital Pyxis and wasted 1.5 mg of the medication at 10:32. Respondent documented
20 administration of .5 mg of the medication at 10:44, but failed to document a post-medication
21 assessment of the patient's pain.

22 29. On February 12, 2011 at 10:45, Respondent withdrew 2 mg of hydromorphone from
23 the hospital Pyxis and wasted .5 mg of the medication at 10:58. Respondent documented
24 administration of 1.5 mg of the medication at 10:52, but failed to document a post-medication
25 assessment of the patient's pain. Respondent withdrew 2 mg of hydromorphone within 13
26 minutes of the prior withdrawal, in excess of physician's orders.

30. On February 12, 2011 at 11:35, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent documented administration of 2 mg of the medication at 11:49, but failed to document an assessment of the patient's pain.

31. On February 12, 2011 at 11:36, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis and wasted 1 mg of the medication at 11:36. Respondent failed to document administration of the remaining 1 mg of the medication, or otherwise account for its disposition. Respondent failed to document an assessment of the patient's pain, and withdrew 2 mg of hydromorphone within 1 minute of the prior withdrawal, in excess of physician's orders.

Patient C:

32. On January 28, 2011 at 16:12, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis and wasted 2 mg of the medication at 16:23. Another nurse had administered hydromorphone to Patient C at 15:02. Respondent failed to document an assessment of the patient's pain, and withdrew 2 mg of hydromorphone within 70 minutes of the prior administration, in excess of physician's orders which specified that the patient was to receive .5 – 1 mg of hydromorphone every six hours as needed.

Patient D:

33. On January 28, 2011 at 07:30, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis and wasted 1.5 mg of the medication at 07:30. Respondent wasted the remaining .5 mg of the medication at 07:45. Respondent failed to document an assessment of the patient's pain. Respondent was not the primary nurse for Patient D.

Patient E:

34. On February 4, 2011 at 11:14, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 11:14 and administration of 1 mg of the medication at 11:18. Respondent failed to document a pain assessment for the patient.

35. On February 4, 2011 at 11:22, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 11:22 and administration of 1 mg of the medication at 11:25. Respondent failed to document a pain

1 assessment for the patient, and administered the medication sooner than the physician's order
2 which specified that the patient should be given 1-2 mg of hydromorphone every six hours as
3 needed.

4 36. On February 4, 2011 at 17:30, Respondent withdrew 2 mg of hydromorphone from
5 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 17:30 and
6 administration of 1 mg of the medication at 17:42. Respondent failed to document a pain
7 assessment for the patient.

8 37. On February 4, 2011 at 17:39, Respondent withdrew 2 mg of hydromorphone from
9 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 17:39 and
10 administration of 1 mg of the medication at 17:43. Respondent failed to document a pain
11 assessment for the patient, and administered the medication sooner than the physician's order
12 which specified that the patient should be given 1-2 mg of hydromorphone every six hours as
13 needed.

14 38. On February 14, 2011 at 07:16, Respondent withdrew 2 mg of hydromorphone from
15 the hospital Pyxis. Respondent charted wastage of 2 mg of the medication at 07:30. Respondent
16 failed to document a pain assessment for the patient, and held the medication for 14 minutes
17 before wasting it.

18 39. On February 14, 2011 at 10:01, Respondent withdrew 2 mg of hydromorphone from
19 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 10:01 and
20 administration of 1 mg of the medication at 10:13. Respondent failed to document a pain
21 assessment for the patient, and administered the medication sooner than the physician's order
22 which specified that the patient should be given 1-2 mg of hydromorphone every four hours as
23 needed.

24 40. On February 14, 2011 at 10:10, Respondent withdrew 2 mg of hydromorphone from
25 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 10:10 and
26 administration of 1 mg of the medication at 10:15. Respondent failed to document a pain
27 assessment for the patient, and administered the medication sooner than the physician's order
28

1 which specified that the patient should be given 1-2 mg of hydromorphone every four hours as
2 needed.

3 41. On February 14, 2011 at 14:13, Respondent withdrew 2 mg of hydromorphone from
4 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 14:13 and
5 administration of 1 mg of the medication at 14:20. Respondent failed to document a pain
6 assessment for the patient.

7 42. On February 14, 2011 at 14:16, Respondent withdrew 2 mg of hydromorphone from
8 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 14:16 and
9 administration of 1 mg of the medication at 14:21. Respondent failed to document a pain
10 assessment for the patient, and administered the medication sooner than the physician's order
11 which specified that the patient should be given 1-2 mg of hydromorphone every four hours as
12 needed.

13 43. On February 14, 2011 at 17:50, Respondent withdrew 2 mg of hydromorphone from
14 the hospital Pyxis. Respondent charted administration of 2 mg of the medication at 17:53.
15 Respondent failed to document a pain assessment for the patient, and administered the medication
16 sooner than the physician's order which specified that the patient should be given 1-2 mg of
17 hydromorphone every four hours as needed.

18 44. On February 18, 2011 at 07:14, Respondent withdrew 2 mg of hydromorphone from
19 the hospital Pyxis. Respondent charted wastage of 2 mg of the medication at 07:34. Respondent
20 failed to document a pain assessment for the patient, and withdrew the medication sooner than the
21 physician's order which specified that the patient should be given 1-2 mg of hydromorphone
22 every four hours as needed. Respondent held the medication for 20 minutes before wasting it.
23 Respondent was not the primary nurse for Patient E on February 18, 2011.

24 45. On February 18, 2011 at 10:02, Respondent withdrew 2 mg of hydromorphone from
25 the hospital Pyxis. Respondent charted administration of 2 mg of the medication at 10:06.
26 Respondent failed to document a pain assessment for the patient.

27 46. On February 18, 2011 at 14:07, Respondent withdrew 2 mg of hydromorphone from
28 the hospital Pyxis. Respondent charted wastage of 2 mg of the medication at 15:12. Respondent

1 failed to document a pain assessment for the patient and held the medication for over one hour
2 before wasting it. Another nurse documented the patient's pain as "0" at 14:08.

3 47. On February 21, 2011 at 07:17, Respondent withdrew 2 mg of hydromorphone from
4 the hospital Pyxis. Respondent charted administration of 2 mg of the medication at 07:54.

5 Respondent failed to document a pain assessment for the patient.

6 48. On February 21, 2011 at 08:59, Respondent withdrew 2 mg of hydromorphone from
7 the hospital Pyxis. Respondent charted wastage of 2 mg of the medication at 12:35. Respondent
8 failed to document a pain assessment for the patient, and withdrew the medication sooner than the
9 physician's order which specified that the patient should be given 1-2 mg of hydromorphone
10 every four hours as needed. Respondent held the medication for three and one half hours before
11 wasting it.

12 49. On February 21, 2011 at 14:02, Respondent withdrew 2 mg of hydromorphone from
13 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 14:02 and
14 administration of 1 mg of the medication at 14:06. Respondent failed to document a pain
15 assessment for the patient.

16 50. On February 21, 2011 at 14:44, Respondent withdrew 2 mg of hydromorphone from
17 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 14:44 and
18 administration of 1 mg of the medication at 14:47. Respondent failed to document a pain
19 assessment for the patient and administered the medication sooner than the physician's order
20 which specified that the patient should be given 1-2 mg of hydromorphone every four hours as
21 needed.

22 51. On February 21, 2011 at 18:07, Respondent withdrew 2 mg of hydromorphone from
23 the hospital Pyxis. Respondent charted wastage of 2 mg of the medication at 18:22. Respondent
24 failed to document a pain assessment for the patient and held the medication for 15 minutes
25 before wasting it.

26 Patient G:

27 52. On February 12, 2011 at 07:11, Respondent withdrew 2 mg of hydromorphone from
28 the hospital Pyxis. Respondent failed to document wastage or administration, or otherwise

account for the disposition of the medication. Respondent failed to document a pain assessment for the patient.

53. On February 12, 2011 at 11:34, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted administration of 2 mg of the medication at 11:50. Respondent failed to document a pain assessment for the patient.

54. On February 12, 2011 at 15:41, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted administration of 2 mg of the medication at 15:48. Respondent failed to document a pain assessment for the patient.

55. On February 12, 2011 at 17:24, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted administration of 2 mg of the medication at 17:28. Respondent failed to document a pain assessment for the patient.

Patient H:

56. On February 15, 2011 at 14:24, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted administration of 2 mg of the medication at 14:30. Respondent failed to document a pain assessment for the patient.

57. On February 15, 2011 at 15:37, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 2 mg of the medication at 16:43. Respondent failed to document a pain assessment for the patient and withdrew the medication sooner than the physician's order which specified that the patient should be given 1-2 mg of hydromorphone every four hours as needed.

58. On February 15, 2011 at 18:39, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 18:39 and administration of 1 mg of the medication at 18:48. Respondent failed to document a pain assessment for the patient and administered the medication sooner than the physician's order which specified that the patient should be given 1-2 mg of hydromorphone every four hours as needed.

59. On February 15, 2011 at 18:52, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 18:52 and

1 administration of 1 mg of the medication at 18:57. Respondent failed to document a pain
2 assessment for the patient and administered the medication sooner than the physician's order
3 which specified that the patient should be given 1-2 mg of hydromorphone every four hours as
4 needed.

5 60. On February 15, 2011 at 16:38, Respondent withdrew 2 mg of hydromorphone from
6 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 16:38 and
7 administration of .5 mg of the medication at 16:45. Respondent failed to document a pain
8 assessment for the patient.

9 61. On February 15, 2011 at 17:06, Respondent withdrew 2 mg of hydromorphone from
10 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 17:06 and
11 administration of .5 mg of the medication at 17:13. Respondent failed to document a pain
12 assessment for the patient and gave the medication without a physician's order.

13 Patient I:

14 62. On February 18, 2011 at 08:47, Respondent withdrew 2 mg of hydromorphone from
15 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 08:47 and
16 administration of .5 mg of the medication at 08:57. Respondent failed to document a pain
17 assessment for the patient.

18 63. On February 18, 2011 at 09:04, Respondent withdrew 2 mg of hydromorphone from
19 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 09:04 and
20 administration of .5 mg of the medication at 09:11. Respondent failed to document a pain
21 assessment for the patient and administered the medication sooner than the physician's order
22 which specified that the patient should be given .5 - 1 mg of hydromorphone every six hours as
23 needed.

24 64. On February 18, 2011 at 19:02, Respondent withdrew 2 mg of hydromorphone from
25 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 19:02 and
26 administration of .5 mg of the medication at 19:08. Respondent failed to document a pain
27 assessment for the patient.
28

65. On February 23, 2011 at 09:27, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 09:27 and wastage of an additional .5 mg of the medication at 11:11. Respondent failed to document a pain assessment for the patient and held .5 mg of the medication for over one and one half hours. Respondent was not the patient's primary nurse on February 23, 2011.

66. On February 23, 2011 at 15:22, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 15:22 and wastage of an additional .5 mg of the medication at 15:52. Respondent held .5 mg of the medication for 30 minutes. Another nurse performed a pain assessment for the patient.

67. On February 23, 2011 at 15:57, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 15:57 and administration of .5 mg of the medication at 15:45, 12 minutes prior to its withdrawal. Respondent failed to document a pain assessment for the patient. Another nurse performed a pain reassessment for the patient.

68. On February 23, 2011 at 18:09, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 18:09 and administration of .5 mg of the medication at 18:15. Respondent failed to document a pain reassessment for the patient and administered the medication sooner than the physician's order which specified that the patient should be given .5 - 1 mg of hydromorphone every six hours as needed.

69. On February 25, 2011 at 07:21, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1.75 mg of the medication at 07:21 and administration of .25 mg of the medication at 07:31. Respondent failed to document a pain assessment for the patient.

70. On February 25, 2011 at 07:46, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1.75 mg of the medication at 07:46 and administration of .25 mg of the medication at 07:51. Respondent failed to document a pain assessment for the patient.

1 71. On February 25, 2011 at 18:46, Respondent withdrew 2 mg of hydromorphone from
2 the hospital Pyxis. Respondent charted wastage of 1.25 mg of the medication at 18:46 and
3 administration of .25 mg of the medication at 18:55. Respondent failed to document wastage,
4 administration, or otherwise account for the remaining .5 mg of the medication.

5 72. On February 27, 2011 at 07:05, Respondent withdrew 2 mg of hydromorphone from
6 the hospital Pyxis. Respondent charted wastage of 2 mg of the medication at 07:33. Respondent
7 held 2 mg of the medication for 28 minutes and failed to perform a pain assessment for the
8 patient. Respondent was not the primary nurse for the patient on February 27, 2011.

9 73. On March 2, 2011 at 13:49, Respondent withdrew 2 mg of hydromorphone from the
10 hospital Pyxis. Respondent charted wastage of 1.75 mg of the medication at 13:49 and
11 administration of .25mg of the medication at 13:54. Respondent failed to perform a pain
12 assessment for the patient.

13 74. On March 2, 2011 at 14:04, Respondent withdrew 2 mg of hydromorphone from the
14 hospital Pyxis. Respondent charted wastage of 1.75 mg of the medication at 14:04 and
15 administration of .25mg of the medication at 14:09. Respondent failed to document a pain
16 assessment for the patient and administered the medication sooner than the physician's order
17 which specified that the patient should be given .25 - .5 mg of hydromorphone every six hours as
18 needed.

19 75. On March 5, 2011 at 06:55, Respondent withdrew 2 mg of hydromorphone from the
20 hospital Pyxis. Respondent failed to document wastage, administration, or otherwise account for
21 the disposition of the medication. Respondent failed to perform a pain assessment for the patient.

22 76. On March 5, 2011 at 08:32, Respondent withdrew 2 mg of hydromorphone from the
23 hospital Pyxis. Respondent charted wastage of 1.75 mg of the medication at 08:32 and
24 administration of .25mg of the medication at 08:54. Respondent failed to document a pain
25 assessment for the patient.

26 Patient J:

27 77. On February 21, 2011 at 09:41, Respondent withdrew 2 mg of hydromorphone from
28 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 09:41 and

1 administration of .5mg of the medication at 09:46. Respondent failed to document a pain
2 assessment for the patient. Respondent was not the primary nurse for the patient on February 21,
3 2011.

4 78. On February 21, 2011 at 09:59, Respondent withdrew 2 mg of hydromorphone from
5 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 09:59 and
6 administration of .5mg of the medication at 10:03. Respondent failed to document a pain
7 assessment for the patient and administered the medication sooner than the physician's order
8 which specified that the patient should be given .5 - 1 mg of hydromorphone every four hours as
9 needed.

10 79. On February 21, 2011 at 13:02, Respondent withdrew 2 mg of hydromorphone from
11 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 13:02 and
12 administration of 1 mg of the medication at 13:08. Respondent failed to document a pain
13 assessment for the patient and administered the medication sooner than the physician's order
14 which specified that the patient should be given .5 - 1 mg of hydromorphone every four hours as
15 needed.

16 80. On February 21, 2011 at 18:37, Respondent withdrew 2 mg of hydromorphone from
17 the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 18:37 and
18 administration of 1 mg of the medication at 18:41. Respondent failed to document a pain
19 assessment for the patient.

20 81. On February 23, 2011 at 07:09, Respondent withdrew 2 mg of hydromorphone from
21 the hospital Pyxis. Respondent failed to document wastage, administration, or otherwise account
22 for the disposition of the medication. Respondent failed to perform a pain assessment for the
23 patient.

24 82. On February 23, 2011 at 12:42, Respondent withdrew 2 mg of hydromorphone from
25 the hospital Pyxis and charted administration of the medication at 12:50. Respondent failed to
26 perform a pain assessment for the patient.

27 Patient K:
28

83. On March 7, 2011 at 07:14, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis and charted wastage of 2 mg of the medication at 08:23. Respondent withdrew the medication sooner than the physician's order which specified that the patient should be given 1 - 2 mg of hydromorphone every four hours as needed. Further, Respondent held the medication for over one hour before wasting it.

84. On March 7, 2011 at 08:46, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis and charted wastage of 1 mg of the medication at 08:46. Respondent documented administration of 1 mg of the medication at 08:52. Respondent failed to perform a pain assessment for the patient, and administered the medication sooner than the physician's order which specified that the patient should be given 1 - 2 mg of hydromorphone every four hours as needed.

85. On March 7, 2011 at 08:51, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 08:51 and administration of 1 mg of the medication at 08:58. Respondent failed to document a pain reassessment for the patient and administered the medication sooner than the physician's order which specified that the patient should be given .5 - 1 mg of hydromorphone every four hours as needed.

86. On March 7, 2011 at 12:38, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 12:38 and administration of 1 mg of the medication at 13:15. Respondent failed to document a pain assessment for the patient and failed to administer the medication until 37 minutes after it was withdrawn.

87. On March 7, 2011 at 12:51, Respondent withdrew 2 mg of hydromorphone from the hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 12:51 and administration of 1 mg of the medication at 13:17, two minutes after the last administration. Respondent failed to document a pain assessment for the patient and failed to administer the medication until 26 minutes after it was withdrawn.

1 88. On March 7, 2011 at 18:13, Respondent withdrew 2 mg of hydromorphone from the
2 hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 18:13 and
3 administration of 1 mg of the medication at 18:19. Respondent failed to document a pain
4 assessment for the patient.

5 89. On March 7, 2011 at 18:15, Respondent withdrew 2 mg of hydromorphone from the
6 hospital Pyxis. Respondent charted wastage of 1 mg of the medication at 18:15 and
7 administration of 1 mg of the medication at 18:22, three minutes after the last administration.
8 Respondent failed to document a pain assessment for the patient.

9 Patient L:

10 90. On February 4, 2011 at 17:02, Respondent withdrew 2 mg of hydromorphone from
11 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 17:02 and
12 administration of an unknown quantity of the medication at 17:30, six minutes after the last
13 administration at 17:24 (see below). The physician's order specified that the patient should be
14 given .5 – 1 mg of hydromorphone every four hours as needed. Respondent failed to document a
15 pain assessment for the patient.

16 91. On February 4, 2011 at 17:18, Respondent withdrew 2 mg of hydromorphone from
17 the hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 17:18 and
18 administration of .5 mg of the medication at 17:24. Respondent failed to document a pain
19 assessment for the patient.

20 92. On February 4, 2011 at 17:02, Respondent charted administration of .5 mg of
21 hydromorphone at 17:08, but did not document withdrawing the medication from the Pyxis.

22 Patient M:

23 93. On March 7, 2011 at 15:03, Respondent withdrew 2 mg of morphine from the
24 hospital Pyxis. Respondent charted administration of 2 mg of the medication at 15:16, but did not
25 document a pain assessment for the patient.

26 94. On March 7, 2011 at 17:30, Respondent withdrew 2 mg of hydromorphone from the
27 hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 17:30 and
28

1 administration of .5 mg of the medication at 17:38, but did not document a pain assessment for
2 the patient.

3 95. On March 7, 2011 at 17:49, Respondent withdrew 2 mg of hydromorphone from the
4 hospital Pyxis. Respondent charted wastage of 1.5 mg of the medication at 17:49 and
5 administration of .5 mg of the medication at 18:08, but did not document a pain assessment for
6 the patient. Further, Respondent administered the medication 30 minutes after the last dose when
7 the physician's order specified .5 – 1 mg of hydromorphone every six hours as needed.

8 SECOND CAUSE FOR DISCIPLINE

9 (ILLEGALLY OBTAIN OR POSSESS CONTROLLED SUBSTANCES)

10 96. Respondent is subject to disciplinary action under Code sections 2762(a), 4060,
11 Health and Safety Code sections 11173(a) and 11377 in that while on duty as a registered nurse at
12 Stanford Hospital and Clinics, Stanford, California, Respondent illegally obtained and/or
13 possessed controlled substances as alleged above in paragraphs 17 to 95.

14 THIRD CAUSE FOR DISCIPLINE

15 (UNPROFESSIONAL CONDUCT)

16 97. Respondent is subject to disciplinary action under Code sections 276(a) in that while
17 on duty as a registered nurse at Stanford Hospital and Clinics, Stanford, California, Respondent
18 acted unprofessionally as alleged above in paragraphs 17 to 95.

19
20 PRAYER

21 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
22 and that following the hearing, the Board of Registered Nursing issue a decision:

23 1. Revoking or suspending Registered Nursing License Number 661425, issued to
24 Jessica Renee Farren;

25 2. Ordering Jessica Renee Farren to pay the Board of Registered Nursing the reasonable
26 costs of the investigation and enforcement of this case, pursuant to Business and Professions
27 Code section 125.3;

28 3. Taking such other and further action as deemed necessary and proper.

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DATED: November 1, 2012

for *Louise Bailey*

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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